



John E. Baldacci, Governor Brend M. Harvey, Commissioner

Stakeholder Advisory / Specialized Services Committee Meeting

December 17, 2010

All documents and materials concerning the Managed Care project reflect MaineCare's current thinking and are subject to change. No materials on the managed care web page, distributed and discussed at meetings or sent in emails or mailings are binding in any way concerning the future procurement process.

Managed MaineCare

Stakeholder Advisory Committee & Specialized Services Committee

AGENDA for December 17, 2010

1:00 - 1:10	I	Welcome & Introductions..... • Review and approve meeting notes	Nadine Edris
1:10 - 1:20	II	Managed MaineCare Initiative Updates.....	Tony Marple
1:20 – 2:20	III	Core Quality Standards Draft.....	Jay Yoe and Maureen Booth
2:20 – 2:35	IV	Purchased Services Presentation.....	Chad Lewis
2:35 – 2:55	V	Report from Listening Sessions.....	Katie Rosingana and Nadine Edris
2:55 – 3:10	VI	Members Standing Committee Report.....	Richard Chaucer and Rose Strout
3:10 – 3:30	VII	Informational Updates • Update on Populations and Services..... • Potential Vendor Meeting Update.....	Julie Fralich Stefanie Nadeau
3:30 – 3:50	VIII	Public Comment	
3:50 – 4:00	XI	Next Steps • Wrap Up/Feedback to the Design Management Committee • January Meeting Agenda: Quality, part 2	

Next meeting: January 21, 2011

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Initiative High-Level Timeline

June 2010	Managed Care Initiative Launched
May 2011	RFP Issued
April 2012	Year 1 Enrollment Begins: Mandatory & Voluntary Populations
Feb. 2013	MCO Readiness Reviews of Year 3 populations
April 2013	Year 2 Enrollment Begins: Waiver to mandate voluntary populations; specialized services are phased in
April 2014	Year 3 enrollment begins: Dual eligibles, waivers



*Department of Health
and Human Services*

Maine People Living
Safe, Healthy and Productive Lives

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

Quality Work Group

Report to MaineCare

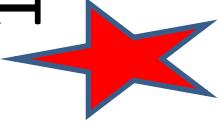
Stakeholders' Advisory Committee

12/17/10

Purpose of Today's Report

1. Major Tasks of Quality Work Group
2. Overview of Quality Standards
3. Focus on 6 sets of standards
 - Delivery network
 - Network management
 - Access
 - Member enrollment & disenrollment
 - Member services
 - Quality management program
4. Discussion
5. Next Steps

Tasks of Quality Work Group

1. Develop *standards* to assure that quality systems, processes and staffing are built into the MCO BEFORE services are delivered.

2. Select *quality measures* to monitor how well the MCO is working.
3. Design a DHHs *oversight program* to detect problems and improve quality with the MCOs and stakeholders.

Overview of Quality Standards

Overview of Quality Standards

- Delivery Network
- Network Management
- Access
- Member enrollment
- Member services
- Care coordination

Overview of Quality Standards

- Member enrollment
- Member services
- Care coordination
- Quality management
- Grievance system
- Data reporting
- Delegation

Approach to Design of Standards

- Preserves all existing rights and protections [e.g., Rule 850; Chapter 109; other state rules and regs].
- Conforms with federal managed care requirements.
- Aligns, where appropriate, with private sector.
- Enhances quality through new structural and process measures.

Focused Review

- Delivery Network
- Network Management
- Access
- Member Enrollment/Disenrollment
- Member Services
- Quality Management

MCO Delivery Network

MCO Delivery Network

- Must meet all covered physical and behavioral health services of the population.
- Must be open to existing MaineCare providers who meet credentialing standards and, at a minimum, are willing to accept FFS rates.
- May not discriminate against providers who serve high-risk populations or specialize in costly treatments.

Criteria in Forming Network

- Anticipated MaineCare enrollment
- Expected service use
- Number, type and qualifications needed to furnish contractual services
- Number of providers not accepting new MaineCare members
- Geographic location of providers
- Accessibility of practices for persons with disabilities
- Required choice of 2 or more PCPs

Special Considerations-Network

- MCO must notify DHHS of planned or unplanned change in network within 24 hours.
- MCO must maintain up to date provider directory, including: specialty, affiliations, languages, locations, hours.
- If PCP is not a women's health specialist, women must have access to health specialist for routine and preventive services in addition to PCP.

Network Management

Provider Credentialing

- MCO must verify that providers are credentialed, licensed, certified or approved as required by State law.
- MCO must have its own credentialing process for determining if providers meet quality standards; decisions must be in writing and subject to appeal.

Cultural Considerations

- MCO must comply with National Standards on Cultural and Linguistically Appropriate Services (CLAS)
- MCO must ensure in-person and telephonic interpreter services to any member upon request.

Access

Geographic Access

- *Primary Care* – within 30 minute travel time
- *Specialty care and hospitals* – within 60 minute travel time.
- Provision of telemedicine is encouraged but does not replace the need for MCO's provider network to meet access standards.

Access to Services

Type of Service	Time to Appointment
Preventive Services	Within 90 days
Routine Primary Care	Within 7 days
Urgent care	Within 24 hours
Routine specialty care	Within 30 days

Out-of-Network Providers

- MCO must cover medically necessary covered services when provider network is unable to provide the needed service.
- MCO must provide member with common carrier transportation to out-of-network provider if necessary.

Second Opinion

- MCO must provide for a second opinion from qualified professional within the network
OR
- Arrange for member to obtain one outside the network at no cost to member.

Member Enrollment/Disenrollment

Member Enrollment

- Members will have a choice of 2 MCOs
- The goal is for members to actively participate in choosing which MCO best meets their needs.
- An enrollment broker will share information with members to help them decide which MCO is best for them. For example, does the member's primary care physician belong to one MCO but not the other?

Member Enrollment

- If a member does not make a selection, he/she will be auto-assigned.
- For example, if a member's primary care physician is in one MCO but not the other, he/she will be auto-assigned to the MCO where the primary care physician is part of the network.

When Can a Member Disenroll?

1. Members can change their mind *for any reason* within 90 days after selecting an MCO.
2. After 90 days, a member must *show cause* when requesting to be disenrolled:
 - Member moves out of state
 - MCO does not cover service that member needs because of moral or religious reasons
 - Poor quality of care, lack of access, lack of experienced providers to meet member's needs
3. During open enrollment every 12 months.

How does a Member Disenroll?

- A member submits written or oral request to DHHS describing why he/she wants to disenroll.
- DHHS may ask the member and/or the MCO to provide information in order to make the decision.
- Decisions must be made within 30 days.
- A member has a right to a fair hearing if dissatisfied with the DHHS determination.

When Can an MCO Request that a Member be Disenrolled?

1. Member moves out of state
2. Member dies
3. Member is no longer eligible for MCO covered services
4. Member is found to have fraudulently used the member ID card.

DHHS must review and approve any request from an MCO about member disenrollment.

Member Cannot be Disenrolled

Because He/She

- is sick
- uses a lot of services
- has developmental or intellectual challenges
- is uncooperative or has disruptive behavior

Member Services

Members Have the Right to:

- Receive information to access needed services;
- Be treated with respect
- Receive information on treatment options
- Participate in his/her health care decisions
- Be free of restraint or seclusion
- Access his/her medical records
- Access MCO performance data

Members Must Receive Clear

Information on Each of the Following:

- MCO providers:
 - Names, locations, languages
 - Status on accepting new patients
 - Hours of operation
- The grievance/fair hearing process.
- Member benefits
- How to access benefits; including access to interpreter services

Members Must Receive Clear Information on Each of the Following:

- How to access after-hours and emergency care
- How to access specialty care
- Cost sharing, if any
- Data on the MCO performance, including member experience
- How to access services not covered by the MCO.

The MCO must Notify Members

When:

- There are changes to policies
- A member's PCP is no longer part of the MCO provider network.

Member Information

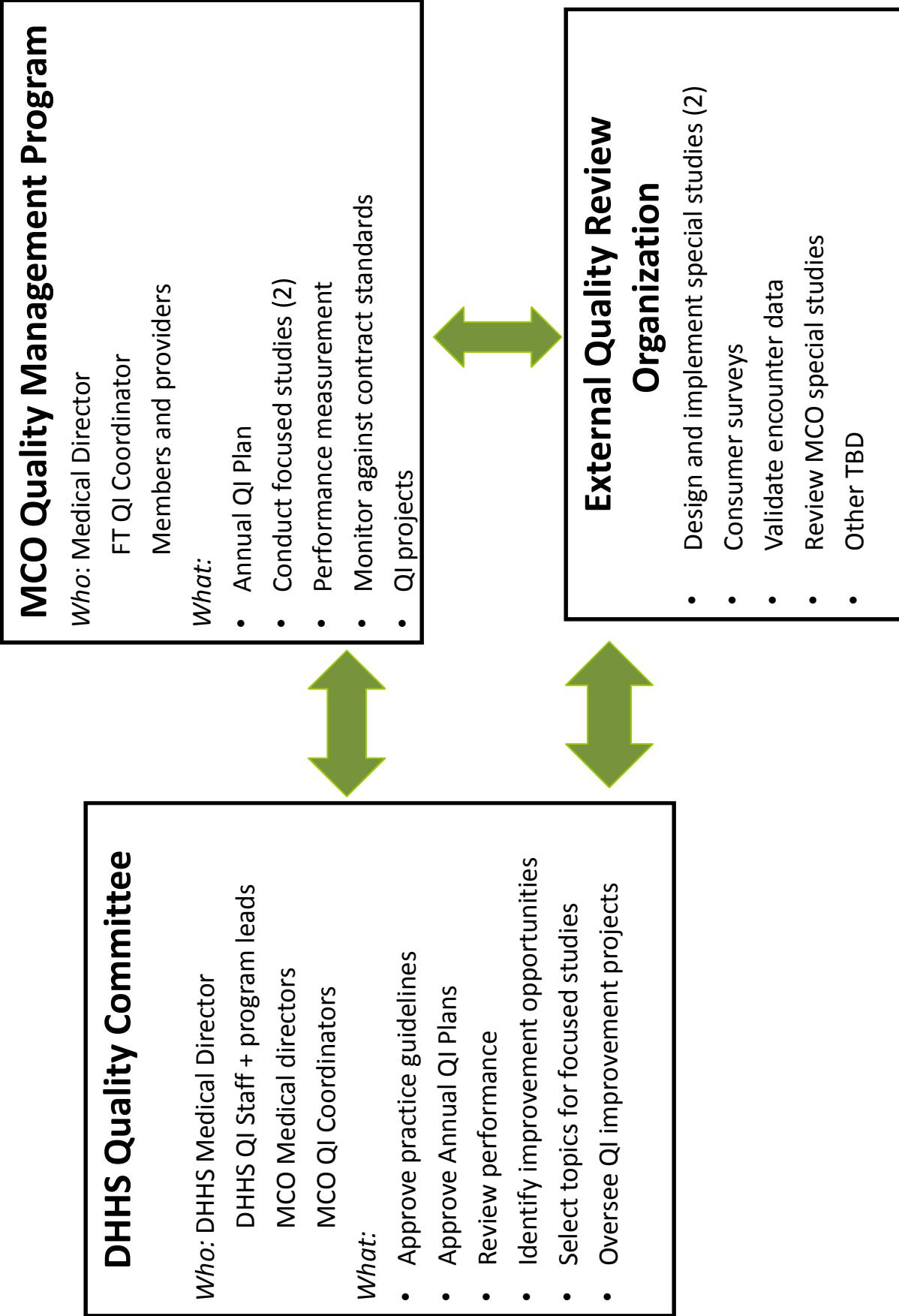
All member information must be presented in languages and formats that are easy to understand

Quality Management

MCO Quality Program

- Makes certain providers use best practices
- Evaluates data to determine if the MCO is making a difference in improving the health and wellbeing of members
- Identifies areas where services should be improved.
- Conducts quality improvement projects
- Engages members and providers in QI

Quality Management Approach



Next Steps

- Review remaining quality standards with members and stakeholders
- Review quality measures that will be used to assess MCO performance

Discussion

- Did we cover the right issues?
- Do the standards provide adequate protection for members?
- Do the standards reflect a quality program?

Managed MaineCare Initiative RFP



DEVELOPMENT

- PROGRAM COMPLETES DRAFT
- PURCHASED SERVICES REVIEWS

DAFS/PURCHASES

- REVIEW/APPROVE RFP
- RFP # ASSIGNED

Managed MaineCare Initiative RFP

LEGAL NOTICE/PUBLICATION*

-KENNEBEC JOURNAL: MINIMUM OF 3 CONSECUTIVE DAYS

-DAFS WEBSITE:

[HTTP://WWW.MAINE.GOV/PURCHASES/RFP/INDEX.HTML](http://www.maine.gov/purchases/rfp/index.html)

-DHHS RFP WEBSITE:

[HTTP://WWW.MAINE.GOV/DHHS/RFP/INDEX.SHTML](http://www.maine.gov/dhhs/rfp/index.shtml)

* FROM THIS POINT FORWARD, ALL CONTACT REGARDING THIS
RFP MUST GO THROUGH THE DESIGNATED RFP COORDINATOR.

Managed MaineCare Initiative

RFP



BIDDERS CONFERENCE

- MIN: 7 DAYS FROM LAST ADVERTISING DATE
- MIN: 15 DAYS BEFORE PROPOSAL DUE DATE

QUESTIONS & ANSWERS

- DEADLINE FOR WRITTEN QUESTIONS
- MIN: 7 DAYS PRIOR TO PROPOSAL DUE DATE

Managed MaineCare Initiative

RFP



PROPOSALS DUE

- SENT TO DAFFS
- REVIEW AND SCORING PROCESS

AWARD NOTIFICATION

- ALL BIDDERS NOTIFIED
- REQUEST STAY OF AWARD
- REQUEST APPEAL HEARING

MaineCare Listening Sessions: September 2010

OVERVIEW

Muskie School of Public Service

Presented to Managed MaineCare Stakeholders Advisory Committee,
Specialized Services Committee and Members Standing Committee

December, 2010



Acknowledgements

- Funding provided by Maine Health Access Foundation (MeHAF)
- Recruitment and logistics handled by Maine Equal Justice Partners (MEJP)



How were members recruited?

- MEJP recruited members via flyers, letters and through word-of mouth through Head Start programs, CAP agencies, child care programs, domestic violence agencies, FQHC's and other service providers
- Members were reimbursed for travel and given \$30 Hannaford gift card for participating

When and Where were Listening Sessions? What was the Format?

- Lewiston: September 9
- Portland: September 16
- Bangor: September 22
- Presque Isle: September 23

Each session was approximately 90 minutes long. A moderator from the Muskie School led the discussion and asked questions.

Who was there?

- There was a total of 50 participants, with group size ranging from 9 to 15
- Variety of ages and circumstances. (Privacy and any identifiable information was protected.)
- DHHS staff did not participate

Major Themes Identified

- Many members are grateful for the services they receive through MaineCare
- Better patient/member supports would improve care
- Members strongly support dental coverage for adult MaineCare members

Identified Themes, *cont'd*

- Members report lack of access to mental health providers
- Prior Authorization (PA) for medications and changes in the Preferred Drug List (PDL) cause problems for members
- Sometimes access to PCPs and specialists is difficult

Identified Themes, *cont'd*

- Providers are not getting paid in a timely manner
- Paperwork sent from the Department is often redundant and communication could be improved
- Prevention should be a priority in MaineCare

Summary

The MaineCare members that we spoke with were very experienced with and passionate about the system in which they are enrolled. The majority felt lucky and grateful to have access to health insurance coverage. Many have had extremely positive experiences with their providers, their case-managers, and their MaineCare coverage overall. At the same time, all agreed that there is room for improvement.

Update:

Potential Vendor Meeting Update, Dec. 10

Meeting Objectives

- Provide background and goals of the Managed MaineCare initiative
- Offer preview of Maine's initial program design ideas for managed care
- Articulate the initiative's proposed timeline and process
- Receive feedback from vendors and answer questions

Meeting Attendance

- 66 attendees in audience
 - Included a combination of potential bidders, providers, advocates and other interested parties
 - Approximately 15 potential bidders

Key Question Topics

- Bureau of Insurance Licensure requirements
 - Risk adjustment
 - Rate cell development
 - Pharmacy management
 - Interaction with Health Care Reform
 - Covered populations and services